**Recovery Kernel**

# DISCONTINUANCE PROTOCOL: OPIOIDS

*Withdrawal nahi hai jo logon ko maarta hai. Uske baad kya aata hai, woh maarta hai.*

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[illegible] [illegible] [illegible] [

category ki saavdhani hai jaise fire extinguisher: kuch aisa jo aapko kabhi istemaal karne ki ummeed nahi rakhni chahiye aur phir bhi rakhte hain.

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## Section 1 — Why This Guide Centres on MAT

Medication-assisted treatment — buprenorphine, methadone, or naltrexone — is, by an extensive evidence base, the single most effective intervention available for opioid use disorder. This guide states that directly and without the hedging some recovery material still applies to it: MAT is not a lesser form of recovery, a crutch, or 'still being addicted to something.' It is a life-saving medical intervention with mortality reduction data behind it that few other addiction treatments can match. Recovery work that runs alongside MAT — the biological, environmental, and identity work in Sections 8 and 9 — is additive to it, not an alternative to it.

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Agar aapko kisi programme ya vyakti dwara yeh kaha gaya hai ki MAT ka matlab hai ki aap 'vastav mein sober nahi hain', toh woh framing sabooton se samarthit nahin hai aur isse jaan jaati hain. Jo maapna zaroori hai, woh jeevit rehna aur kaam karna hai, na ki kisi vyakti ki system mein kaun se khaas molecules maujood hain ya nahin.

## Section 2 — The Withdrawal Timeline

| Timeline | What's Happening | What to Expect | What to Do |
|---|---|---|---|
| □□□□ □-□□ (□□□□□□□, □□□□□□ □□□-□□□□□□□□□ □□□□□) | Opioid receptor occupancy gir raha hai; system bina apne apekshit input ke chhod gaya. | □□□□□□, □□□□□□□□□□□ □□□ □□□□, □□□□□ □□□, □□□□□□ □□□□, □□□ □□□□, □□□□□□□ □□□□□□ | MAT initiation, if pursued, often begins in this window — buprenorphine specifically requires the person to be in mild-to-moderate withdrawal already before the first dose to avoid precipitating |

| Timeline | What's Happening | What to Expect | What to Do |
|---|---|---|---|
| | | | worse withdrawal. |
| Days 1-3 (peak physical symptoms) | Full withdrawal syndrome active; yeh sabse mushkil physical stretch hai | [illegible], [illegible], [illegible], [illegible], [illegible], [illegible] [illegible], [illegible] [illegible] [illegible]-[illegible], [illegible] [illegible] [illegible], [illegible] | Medical supervision or MAT sharply reduces this severity. This is also the highest-risk window for someone deciding the suffering isn't survivable and returning to use at a now-dangerous dose — see Section 0. |
| Days 3-10 (post-acute physical resolution, psychological symptoms peaking) | Physical withdrawal resolving; endorphin and dopamine systems at their lowest point | [illegible], [illegible], [illegible], [illegible], [illegible], [illegible] | Full supplement stack begins (Section 9). As soon as physically possible, exercise, even a short walk. Sleep management is one of the strongest predictors of avoiding early relapse — prioritise it directly. |
| Weeks 1-4 | [illegible] [illegible] [illegible] [illegible]-[illegible] [illegible] [illegible]; [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] | Day-to-day gradual improvement with real variability; PAWS episodes are likely; emotional volatility; episodic but powerful cravings. | Full protocol running. Community connection matters more than it may feel like it should — isolation is one of the strongest relapse predictors in this specific recovery. |
| Months 1-6 | Significant receptor upregulation; dopamine and endorphin systems actively rebuilding; opioid-induced hyperalgesia | Progressive real improvement; genuine moments of natural pleasure returning; pain sensitivity normalising | Yeh woh jagah hai jahan kaam zaroori rehne ke bajaye tikau ho jaata hai. Pehchaan par kaam (Section 9) |

| Timeline | What's Happening | What to Expect | What to Do |
|---|---|---|---|
| | (amplified pain sensitivity from the opioids themselves) resolving | | yahaan uchit hota hai, pehle nahi. |
| Months 6-18+ | Mu-opioid [illegible] [illegible] [illegible] [illegible] [illegible]; [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] | Natural enjoyment and connection accessible without chemical support; PAWS episodes rare; cravings contextual rather than constant | For most people, full endorphin system recovery can be achieved within 12–18 months of sustained recovery, irrespective of whether that recovery involves MAT or not. |

## Section 3 — How Long Until the Brain Is Actually Back to Normal

Full mu-opioid receptor density recovery, in most people, takes 12-18 months of sustained recovery — a timeline consistent with the other longer-recovery substances in this series. Post-acute withdrawal syndrome (PAWS) specifically can run 18-24 months, and for fentanyl-involved recovery specifically, that window may run longer still, given fentanyl's exceptional receptor-binding potency compared to other opioids.

[illegible]

Agar aap ko aath mahine ho gaye hain aur ab bhi PAWS waves aa rahi hain — achanak anxiety, bina kisi saaf trigger ke craving, ya kuch din aise jo bilkul bejaan lagte hain — toh iska matlab yeh nahi ki mehnat rang nahi laa rahi. Yeh theek wahi jagah hai jahan sachcha samay aapko le ja raha hai. Yahaan ka finish line ek saal se zyada mein hai, aur yeh jaanna pehle se hi yeh badalne ke liye hai ki mushkil aath mahina kaisa lagega, na ki iska matlab yeh hai ki mushkil mahina khatam ho jayega.

## Section 4 — [illegible]

- [illegible], [illegible] [illegible] [illegible] [illegible]—[illegible], [illegible], [illegible] [illegible] [illegible] [illegible] [illegible] [illegible], [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
- Amplified pain sensitivity (opioid-induced hyperalgesia) — a real, documented phenomenon where the nervous system becomes temporarily more sensitive to pain than it was even before opioid use began, as it

recalibrates. This resolves over the timeline in Section 2 and Section 3, but it's disorienting while it's happening.

- [illegible]
- Cravings jo bina kisi saaf trigger ke aa sakte hain, khaaskar PAWS waves ke dauraan—yeh neurobiological hai, kam samarpana ka sanket nahi.
- A pronounced sense of social disconnection or loneliness in G-allele OPRM1 carriers specifically (Section 5) — the same receptor mediating opioid reward also mediates endorphin-based social bonding, so its depletion can feel like isolation itself, not just drug craving.

## Section 5 — Genetic Cross-Reference

| Gene | What It Governs | Opioid Recovery Relevance |
|---|---|---|
| OPRM1 (A118G) | Mu-opioid receptor structure — the primary receptor all opioids act on | [illegible] |
| CYP2D6 | Metabolises codeine, tramadol, and many other opioids to their active or inactive forms | Poor metabolisers get little to no effect from codeine or tramadol, which can drive dose escalation chasing an effect that specific drug will never produce for them. Ultra-rapid metabolisers convert codeine to morphine dangerously fast — a documented mechanism of fatality even at standard prescribed doses. Also affects buprenorphine metabolism directly relevant to MAT dosing. |
| CYP3A4 | Primary metabolizer of fentanyl, oxycodone, | The dominant pharmacokinetic gene for the opioids most people in this |

| Gene | What It Governs | Opioid Recovery Relevance |
|---|---|---|
| | methadone, and buprenorphine | recovery are actually navigating, including both primary MAT medications. Inhibited CYP3A4 — from genetics or drug interactions (certain antibiotics, antifungals, even grapefruit) — can cause dangerous accumulation of these medications. CYP3A4 inducers can precipitate MAT withdrawal by clearing the medication too fast. Inform every prescriber of every medication. |
| ABCB1 (□□-□□□□□□□□□□□□□□) | Blood-brain barrier drug transport | Variants affect how much opioid crosses into the brain from a given dose — some variants allow greater CNS penetration, producing stronger effects from identical doses and plausibly accelerating dependence development. Also affects buprenorphine and methadone CNS concentration, relevant to MAT optimization. |
| DRD2 (Taq1A, A1 allele) | Dopamine D2 □□□□□□□□□ □□□□□ | A1 □□□□□□□□□ □□□ □□□□ 30% □□ □□□□□□□□□ □□□□□ — □□□□□□□□ □□□□□□□□□□□ □□□□□□□□□□ OPRM1 G-allele □□ □□□ □□□□□, □□ □□□□□□ □□ □□□□□□□□ □□□□ □□□□□□□ □□□□□ □□ □□ □□□ □□□□□□□□ □□□□ □□□□ □□ □□□□□□□ □□□□-□□□□□□□ □□□□ □□□□ □□□□ □□ — □□ □□□□□□□□ □□□ □□□□-□□□□□□ □□□□ □□□□□□□□ □□□ □□ □□□
| COMT | Dopamine clearance aur dard ka signal process karna | Relevant specifically for anyone whose opioid use began with legitimate pain treatment — COMT variants affect baseline pain sensitivity independent of opioid exposure, meaning undertreated pain may still need its own dedicated management track (Section 6) even once the opioid dependence itself is addressed. |
| MTHFR | Methylation — □□□□□□□□□□□□□□□□□ □□□□□□□□ | Baseline dopamine aur serotonin synthesis ki kami jiske liye opioids ne shayad thoda compensation kiya ho. Is recovery mein 5-MTHF support foundational hai, not optional. |
| GABRA2 | GABA-A □□□□□□□□ □□□□□-2 □□□□□□□ — □□□□□□□ □□□□□□□□□□ □□□ | Not the primary opioid gene, but a genuine compounding factor, for two reasons: it's the same GABA architecture underlying the common opioid-plus-benzodiazepine or opioid- |

| Gene | What It Governs | Opioid Recovery Relevance |
|---|---|---|
| | | plus-alcohol co-use pattern (each substance targeting a different receptor system for a related anxiety/inhibition problem), and it drives the specific combined profile detailed below. |

### *How COMT Status Changes What Opioids Actually Feel Like*

COMT □□ □□□□□□□□□ □□□□ □□ □□ □□□□□□□□ □□ □□□□ □□□□□ □□□□□ □□□□□ □□□ □□□□ □□□, □□ □□ □□□□□□ □□□ □□ □□□ □□ □□□□ □□□□ □□ □□ □□□□ □□□ □□ □□□□□□□ □□ □□□ □□□□□□ □□□□□□ □□□ □□□□ □□ □□□ □□□ — □ □□□□ □□ □□□□□ □□□□□ □□□□ □□□, □□□□□ □□□□ □□ □□ □□□□□□ □□□□□ □□□□□□ □□□□□ □□□□

| COMT Profile | Baseline Before Opioids | Opioids Specifically Provided |
|---|---|---|
| Val/Val ('Warrior') — □□□ □□□□□□□□□, □□ □□□□□□□ □□□□□□□□ □□□ | □□□□□ □□□□ □□□□ □□□ □□ □□□□□□□□ □□□□□ □□□□; □□□□ □□□□ □□□□□□ □□ □□ □□□□□□□ □□ □□□□□□ □□ □□ □□□□□□ □□□□□ | Opioids ne ke liye jo rahat dete hain woh doosre profiles se alag hai — 'akhirkaar, shaanti' jaisa nahi aur zyada 'akhirkaar, itna aaramdayak ki tezi ka peecha karna band kar paayein' jaisa. Yeh profile pure opioid dependence mein utna common nahi hai jitna stimulant dependence mein hai, lekin jab yeh maujood hota hai, toh recovery ko sirf shaanti par dhyaan dene wale kaam se zyada, asli high-intensity outlets ki zaroorat hoti hai. |
| Met/Met ('□□□□□□□□□□□□' / '□□□□□□') — □□□□ □□□□□□, □□□□ □□□□ □□□□-□□□□□□□□ □□□□ | □□□□□ □□□□ □□□□ □□□ □□□□□□ □□ □□□□□□□□□□□□ □□□□ □□; □□□□ □□□□ □□□□□□ □□ □□□□□ □□ □□ □□□□□□□□ □□□□□ □□□□ □□□□ □□ □□□□□□□□□ □□□□ □□□ | □□ □□□□ □□□□□□□ □□□□□□-□□□□□□ □□□□□□□□ □□□ □□□□□□□ □□ □□□□□-□□□□□□ □□□ (□□□□□□ 5 □□ □□□□□□□□ □□□□□□) □□□□ □□□ □□ □□ □□□□□ □□□ □□ □□□□□□□□□ □□□□ □□□□□□□ □□ □□□□ □□□□ □□ - □□ □□□□ □□□□ □□□□□□□ □□□□ □□□□ □□, □□□□□ □□□□ □□□ □□ □□ □□□□ □□ □□ □□□□ □□□□□□□□ □□□□□ □□□□ □□□ □□ □□□□ □□ □□□□ □□□ □□ □□ □□□□□□□□ □□ □□ □□□□ □□ □□□□ □□□ □□□□ □□ □□□□□□ □□□□□-□□□□□□ □□□□□□□ □□□□ □□□□□□ □□□ □□□□ □□, □□□□□□□ □□□□□□□□ □□□□ □□ □□□ □□□□ □□□□□□□ □□□□-□□□□□□□□ □□□□□□□ □□□□ □□□
| Heterozygous (Val/Met) | An intermediate baseline between the two profiles above. | □□□□□ □□ □□□□□□ □□□□ □□ - □□□ □□□□□□□□ □□□□□□□ □□□□ □□ □□□□ □□□□ □□□□, □□□ □□□□ □□□□□□□ □□□□ □□ □□□□ □□□□ □□□□ - □□□□ □□□□ □□ □□□□□□ □□ □□ □□ □□□□□□□□□ □□□□□□□□ □□□□□ □□□ □□□□ |

### *GABRA2 and the 'Anxious Depressant Pattern'*

This is worth naming directly rather than leaving GABRA2 as a minor footnote in the table above. Your Compendium's own Gene-Substance Matrix identifies a specific combined profile — GABRA2 high-risk plus COMT Met/Met — as the 'Anxious Depressant Pattern,' relevant across alcohol, benzodiazepines, and opioids: compromised self-soothing capacity (COMT) stacked on compromised inhibitory tone (GABRA2), producing the most rapid documented progression to dependence of any combined profile in that matrix.

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If yeh combination aap par lagu hota hai, toh do baatein saaf taur par jaanna zaroori hain. Pehla, yahi wajah hai ki polysubstance use — opioids ke saath benzodiazepine ya alcohol — is khaas profile mein itna aam pattern kyun hai: opioid stress-system aur dard se rahat wali taraf jawab de raha hai, jabki GABA-targeting substance alag se underpowered-brakes wali taraf jawab de raha hai, aur dono mein se koi bhi ek doosre jo kar raha hai use poori tarah cover nahi karta. Doosra, iska matlab hai ki is profile ke liye recovery ko sach mein dono systems ko saath mein address karne ki zaroorat hai — yeh guide mein opioid-focused kaam, aur agar koi substance ho toh Recovery Kernel ke Benzodiazepine ya Alcohol guides mein GABA-focused kaam. was also part of the pattern — rather than treating the opioid dependence as the whole picture.

### *Phenotyping Without Test Results*

- Opioids ne aapko woh dard mein rahat de paaye jo kisi aur cheez se nahi ho paya, bhale hi doze aise hon jinko doosron ne kaafi samjha? → Sambhav OPRM1 G-allele ya ABCB1 variant. CYP2D6 testing ko tarjeeh dena uchit hoga.
- Opioids ne aapko kisi aur cheez se zyada normal, connected aur at ease mehsoos karaya? $\rightarrow$ Strong OPRM1 involvement aur ek likely endorphin-system deficit. Social bonding work (Section 9) aapke recovery ke liye central hai, supplementary nahi.
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- Baseline emptiness ya anhedonia aapka sthayi anubhav hai, opioid istemaal se alag? → Sambhavatah DRD2 kami ke saath MTHFR ka sankraman. Dopamine samarthan sarvochch prathmikta hai.

## Section 6 — Special Populations

| Situation | What Makes It Different |
|---|---|
| Chronic pain as the entry point | For a significant portion of people in opioid recovery, genuine chronic pain was the original and remains a real, ongoing condition. Recognizing the genetic vulnerability that drove dependence does |

| Situation | What Makes It Different |
|---|---|
| | not mean the pain itself was never real, and it does not disappear when the opioid does. This population needs a pain management track running parallel to, not replaced by, the recovery track — physical therapy, non-opioid pain management, and in some cases buprenorphine specifically prescribed for pain (a legitimate, distinct use case from its role in MAT for dependence) indefinitely alongside recovery work. Unmanaged pain is one of the most predictable pathways back to opioid use of anything in this guide. |
| Fentanyl-contaminated supply | The current illicit opioid and, increasingly, illicit stimulant and counterfeit pill supply is widely contaminated with fentanyl, which is dramatically more potent than heroin or prescription opioids by weight. Someone with tolerance built on heroin or pills has no reliable protection against a fentanyl-contaminated batch — the potency differential can be fatal at a dose that would have been unremarkable with the substance they believed they were using. Fentanyl test strips (available through most harm reduction organizations) and naloxone access are not optional precautions for anyone with any current opioid use — they are baseline safety equipment, the same category as Section 0's fire-extinguisher framing. |
| Intravenous (IV)/Injection route specifically | Recovery Kernel □□ Ears, Eyes, □□ Teeth □□□□ □□□ □□□□ □□□□□□□□ □□□□□□□ □□ □□□ □□□□ □□ — □□□□□□□□ □□□□ □□□□□□□, □□□□□□□□□□□□□, □□□□□□□□□□ □□ □□ □□, □□ □□□□□□□ □□□□□□□□ □□□□□□□□□ □□ □□□□□□□ □□□□ □□□□□□□ □□□□□□-□□□ □□□□□□□□ □□□□□□ □□, □□□ □□□□ □□□□ — □□ □□□□□□ □□□□□□□□□□ □□ □□□□□ □□□□□□□ □□□□□□ □□□ □□□□□□□□□□ □□, □□□ □□ □□□□□□□ □□□□□ □□□□□□ □□□ □□□ |

## *Substitution and Tapering Landscape*

For anyone tapering a prescription opioid specifically, the substance itself changes what the taper actually looks like. This is a landscape overview, not an individual dosing schedule — the exact numbers require a physician who knows the specific patient, current dose, and duration. What follows is the framework worth bringing into that conversation.

| Substance | What Makes It Complex to Taper | The General Approach |
|---|---|---|
| Fentanyl (patch or illicit) | □□□□□□□ □□□□□ □□ □□□□ □□ □□ □□□□ □□□□□□□ □□□ □□□ □□ □□□□ □□□□□□□□ □□□□□□□□ □□□□□□□ □□; □□□□□□□□□□□ □□□ □□□□□ □□□□□□ □□□ □□□□□□□□□□□□□ □□□□□□ □□ (□□□□□, □□□□□ □□ □□□□□□ □□ □□□ □□□□□□□□□ □□□ □□□□□ □□ □□□□□□□□ □□□□ □□□) □□□□□□□□□□□□ □□ □□□□ | Patch tapers typically move to the next-lowest patch strength on an extended interval (commonly every 2-4 weeks, following the same percentage-based principle used throughout this library), sometimes with an oral bridge for the gap between patch strengths. Illicit fentanyl tapering is rarely done as a direct patch-to-patch reduction — it usually requires converting to a measurable, prescribable form first |

| Substance | What Makes It Complex to Taper | The General Approach |
|---|---|---|
| | | (see MAT, Section 8). |
| Oxycodone ER (OxyContin) □□ □□□□ □□□□□□□□□□-□□□□□ □□□□□ □□□□□□□□ | □□□□□□□□□□-□□□□□□ □□□□□□□□□□ □□ □□□□ □□ □□ □□□□□ □□ □□□□ □□ □□□ □□□□□□ □□ □□□□□ □□ □□□□ □□□□□ □□□ □□□□ □□□ - □□ □□ □□ □□□□ □□ □□□□ □□□□□ □□, □□ □□□ □□□□□ □□□ □□□□ □□ □□□□ □□ □□ □□□□ □□□ □□□□□ □□□□ □□□ | Extended-release dose mein dheere-dheere kami karna, jo aam taur par 10-25% har 1-4 hafton mein hota hai, yeh istemaal ki avadhi aur gambhirta par nirbhar karta hai, kabhi-kabhi transition ke dauran breakthrough symptoms ke liye ek short-acting formulation bhi uplabdh ho sakta hai — yeh faisla prescribing physician ka hoga, khud se kiya gaya addition nahi. |
| Hydromorphone (Dilaudid) | Short half-life aur zyada potent hone ke kaaran morphine ki tulna mein withdrawal jaldi aur zyada concentrate ho jaata hai, jo longer-acting opioids ke saath hota hai, bilkul ussi tarah jaisa short-half-life problem venlafaxine ke SSRI/SNRI guide mein document kiya gaya tha. | □□□□□ □□ □□□□ □□□ □□ □□□ □□□□ □□□□ □□□□□□ □□□ □□□□□□□□□ (□□□□□□) □□□□ □□□□ □□, □□□□ □□□□□ □□□ □□ □□□□□ □□□□ □□□ □□□□ □□□□ □□□□□□□□□ □□ □□□, □ □□ □□□□ □□□□-□□□□□□□□ □□□ □□ □□ □□□□ — □□ □□□□□□□□ □□ □□□□□□□□ □□□□□□□ □□□□□ □□, □□□ □□□□□□□□□□□□ □□□□, □□ □□□□□ □□□□□ □□□□□ □□□□ □□ □□□□□ □□□ □□□□□□□□ □□□□□□ □□□□□□□□ □□□□ □□□□□□ |
| Tapentadol (Nucynta) | □□ □□□□□□ □□□ □□□□ □□ □□□□□□□ □□□ □□□□□□□□□□ — □□□□-□□□□□□ □□□□□□□□ □□ □□□□□□□□□□□□□ □□□□□□□ □□□□□□□□ □□□□□ □□ □□□ □□□ □□□□□ □□□□□□ □□ □□□□□ □□□□□□□□□□ □□ □□□□ □□ □□ □□□ □□□ □□□ □□□□ □□□ □□□□ □□□, □□□□□ □□□□ □□□□□□ □□□□□□□□ □□□□□□□□□□□ □□ □□□ □□□□-□□□□ □□□□ □□: □□□□□□□□ □□□□□□□□□□□□□ □□□□□□□ □□□□□, □□□□□□ □□ □□□□ □□□ □□□□□ □□ □□□□ □□ □□□□ □□, □□□□□ □□□□ □□ □□□ □□□□□□□ □□□□ □□ □□□□ □□ □□ □□□□ □□□□□□□□ □□□□ □□ □□ □□□ □□ (□□□□ 5 □□ □□□□□□ □□□ COMT Met/Met □□□□□□□□ □□ □□□□ □□□□□ □□□ □□ □□□□□ □□□□ □□□□□ □□)□ | Agar tapentadol achhe se bardasht nahi kiya gaya, toh yeh ek prescriber ke liye sach mein upyogi jaankari hai — yeh is baat ki taraf ishara kar sakta hai ki samasya opioid dosing se zyada uske dual mechanism mein hai, aur sirf usi ki alag dose ke bajaye poori tarah se alag dawai chunne ki taraf, na ki sirf ek alag dose ki. |

## *Pharma's Opioid-Sparing Substitute: Gabapentin and Pregabalin*

A common current prescribing pattern deserves the same direct treatment this library already gives it elsewhere: gabapentin and pregabalin are frequently offered specifically to avoid prescribing an opioid, or to support an opioid taper by

covering some of the nerve-pain component. This can be a legitimate, useful tool. It can also become its own unaccountable, indefinite prescription if nobody is tracking an exit date.

⚠ [illegible]

The Recovery Kernel's own material on gabapentinoids applies directly here: these are increasingly recognized as carrying real dependence and withdrawal risk of their own, including seizure risk at high doses discontinued abruptly, despite historically being prescribed as though they were risk-free. If gabapentin or pregabalin was offered as an opioid alternative, the same accountability questions from this library's Section on substitute medications apply: what is the stated exit date or review point, is this a time-limited bridge or open-ended maintenance, and what would tapering this specific medication look like if it needs to end. A medication that avoided one dependence risk is not automatically free of dependence risk itself.

### *Addressing the Underlying Cause, Not Just the Taper*

For the significant population in Section 6 whose opioid use began with genuine pain, the taper itself is necessary but incomplete — per Section 1 and Section 6's framing, unmanaged pain is one of the most predictable pathways back to opioid use of anything in this entire guide. Resolving what the pain actually is, and treating it directly, is not a parallel nice-to-have. It's a required part of making the taper hold.

- [illegible] - [illegible], [illegible], [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] - [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]
- Physical therapy aur non-opioid pharmacological pain management, jo ek pain specialist ke saath taper karne waale doctor dwara kiya jaaye.
- Ketamine infusion therapy — a real, established option for certain refractory chronic pain conditions (complex regional pain syndrome, fibromyalgia, and some forms of neuropathic pain), delivered as a sub-anesthetic infusion in a monitored clinical setting, distinct from the discontinuation-support framing given to ketamine elsewhere in this series. Worth raising directly with a pain specialist if standard non-opioid options haven't been sufficient.

**[illegible] SANCTUARY**

If nobody has ever actually diagnosed why the pain exists — only ever treated that it exists — that's worth naming to a physician plainly. Tapering the medication that was managing an unidentified problem, without also pursuing what the problem actually is, is exactly the setup this guide is trying to help avoid.

## Section 7 — Use Pattern Classification

| Level | Pattern | Risk | Posture |
|---|---|---|---|
| Prescribed, short-term, no escalation | A legitimate prescription used as directed, for a limited duration | Kam, par zero nahi — physical dependence regular istemaal se 1-2 hafton mein shuru ho sakta hai, bhale hi galat istemaal na kiya gaya ho. | Prescribing doctor se plan kiya gaya taper karna, ki turant band karne se zyada surakshit tareeka hai, yahan bhi. |
| 2 — Prescribed, longer-term, or mild escalation | Regular use beyond the original prescribed duration, or gradually increasing dose to maintain the same effect | Moderate — □□□□□□□ □□□□□□□□ □□□□□□□ □□□□ □□ □□□□□□□ □□ | Ek supervised taper yahaan zaroori hai; achanak band karne se kaafi zyada withdrawal ho sakta hai, aur yeh bilkul woh janta hai jiske liye MAT par baat karna, chahe kitni bhi kam der ke liye kyun na ho, pehle se hi faydemand hai. |
| 3 — Regular non-prescribed or significantly escalated use | Overusing the prescribed dose, taking someone else's medicine, or regular illegal use without constant round-the-clock dosing. | High | Medical involvement is strongly advised before any attempt to stop. MAT should be a real part of this conversation, not a last resort. |
| Dependent, daily use including to avoid withdrawal | Daily or near-daily use, including use specifically to prevent withdrawal symptoms rather than for effect | Severe — □□ □□□□□ □□□□□□ 8 □□ □□□□□ □□ □□□□□□□ □□□□□□□□□ □□ □□□ □□□□ □□□ □□ | Unsupervised cessation ka prayas na karein. Section 0 ki relapse-overdose warning is varg (population) par poori taakat se lagu hoti hai. |

## Section 8 — Medication-Assisted Treatment and Detox

| Dawai | Mechanism | Clinical Notes |
|---|---|---|
| Buprenorphine (Suboxone, Subutex, Sublocade) | □□□□□ □□□□□□ □□□□□□□□ — □□ □□□□□□□□ □□ □□□□□□□□ □□□ □□ □□□□□□ □□□□ □□ □□□□ □□□□□□□□□ □□ □□□□□□□□ □□ □□□□ □□ □□□, □□□□□□ □□ □□□□□□ □□□□□□ □□□□ □□ □□ □□□ | Requires the person to be in mild-to-moderate withdrawal already before the first dose (to avoid precipitated withdrawal). Can be prescribed in an office-based setting by trained providers, |

| Dawai | Mechanism | Clinical Notes |
|---|---|---|
| | [illegible] | which meaningfully improves access compared to methadone's clinic-based model. |
| Methadone | [illegible], [illegible] — [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] | Most cases require daily dosing at a licensed opioid treatment programme, at least initially. There is a strong evidence base, especially for higher-severity or longer-duration dependence. CYP3A4 status (Section 5) affects dosing. |
| Naltrexone (oral or extended-release Vivitrol) | [illegible] — [illegible] [illegible] [illegible] [illegible] [illegible] [illegible], [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] | Requires full detoxification (typically 7-10 days opioid-free) before starting, since it will precipitate severe withdrawal if opioids are still active in the system. OPRM1 G-allele carriers (Section 5) show notably stronger response — genuinely useful, actionable treatment-selection information. |

[illegible]

MAT selection ek asli clinical nirnay hai jiska seedha fayda Section 5 mein diye gaye genetic jaankari se hota hai — ise uss vyakti ke paas le jaaye jo yeh aapke saath manage kar raha hai.

# Section 9 — The Recovery Protocol

## Tier 1 — [illegible] (Day 1 se)

| Support | Role |
|---|---|
| DLPA (DL-Phenylalanine) | Endorphin system precursor support — start Day 1 if eating. |
| NAC (600mg twice daily) | Glutamate homeostasis aur craving kam karna. |
| 5-MTHF | Foundational methylation aur neurotransmitter synthesis support. |
| [illegible] | General nervous system support and sleep. |
| Omega-3 (EPA-[illegible]) | General neurological support during a period of significant system rebuilding. |

## Tier 2 — Medical

- MAT for Section 8, as the primary medical intervention, not an adjunct.
- Pain management track (Section 6) running in parallel if chronic pain is present — this is not optional for that population.

- Bloodborne infection testing and treatment if injection use history is present (Section 6).

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Worth naming directly because it's inexpensive, genuinely useful, and not often mentioned in recovery material: time-locked medication safes exist specifically for situations like a taper, where the goal is controlled, scheduled access rather than either full self-access or no access at all. A trusted person — a partner, family member, or other overseer — loads the doses according to the taper schedule set with the prescribing physician, and the device physically will not open until the scheduled time, regardless of how the person taking the medication feels in the moment. This directly addresses the same access-and-friction mechanism named elsewhere in □□ □□□□□□□□□ □□ □□□ □□□□ □□□□ □□□□□□□□: □□□□ □□□□□□□ □□ □□□□□□□□ □□□□□ □□ □□□ □□□□□□□□□ □□□□□ □□ □□□□□ □□□□ □□ □□□□□□ □□ □□□□□ □□□□ □□ □□□ □□ □□□□□□□□, □□□□□ □□□ □□ □□□□□□ □□, □ □□ □□□□ □□□□□□□□□□□□□

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Standard warnings apply, aur woh zaroori hain: yeh ek support tool hai, na ki medical taper plan ka vikalp, aur na hi MAT ya physician supervision ka vikalp jahan woh darshaye gaye hain. Iske liye ek sach mein bharosemand, lagatar uplabdh nigrani karne wala chahiye — agar jo vyakti isse control kar raha hai woh bharosemand nahi hai toh yeh tool kaam nahi karega, aur agar bina iske kyun par saaf baat-cheet kiye introduce kiya gaya toh yeh jhagda ya naaraazgi ka sabab ban sakta hai. Yeh kisi ko device ke bahar se dawai ya padarth prapt karne se nahi rokta, isliye yeh ek khaas khatre (tapering medication ka turant aur aniyantrit dose lena) ko sambodhit karta hai, na ki □□□□ □□□□□□□ □□□□□□□□ □□□□□□ □□□ □□□□ □ □□□□ □□□ □□ □□□□□□□□□ □□□□□□□ □□□□ □□ - □□□ □□□ □□ □□ □□□□ □□ □□ □□□ □□□ □□□□□□□□□ □□□□ □□ □□□□ □□□□ □□ □□ □□□□□□ □□ □□□□□ □□□□□ □□ □□ □□□□□□ 7 □□ □□□□-□□□□□ □□□□ □□□□□□□□□ □□□ □□□□ □□ □□□ □□ □□□□□□□ □□□□□□□ □□□□ □□□□ □□□□ □□□□□ - □□ □□□□□□□□ □□□□□□ □□ □□□ □□ □□□□□□□□□□ □□□□□□ □□, □ □□ □□□□ □□□□□□□

### *Illicit-Origin Substances: Kyun 'Taper Khatam Hone Tak Bas Guzar Jana Hai' Khud Ek Khatra Hai*

This deserves direct, serious treatment rather than a passing mention, because the risk is categorically different from anything else in this guide. A medication from a licensed pharmacy has a documented chain of custody — manufactured under regulated conditions, verified in dose and composition, traceable at every step from production to the bottle in hand. A substance obtained outside that system has none of this. No paperwork, no certification of origin, no verification of what's actually in it, no way to know what it passed through or was combined with before reaching the person taking it. This is not a □□□□□ □□□□□□ □□ □□□ □□□□□ □□ □□□□□ □□□□ - □□ □□□□□ □□ □□□□ □□ □□□ □□ □□□□□ □□□□ □□ □□ □□ □□□ □□ □□□ □□□□ □□□□ □□□□ □□ □□□□ □□ □□□ □□□□□ □□□□□

**MEDICAL EMERGENCY**

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- Genuine community aur connection — yeh by chance nahi hai, balki ek structure ka hissa hai, khaaskar jab hum dekhte hain ki opioid receptor system kitne seedhe tareeke se social bonding reward ko mediate karta hai (Section 5).
- Cold exposure, laughter, aur sangeet—har ek ke paas asli, agar thode se, endorphin-activate karne wale prabhav hain jinhe saath mein istemaal kiya ja sakta hai.

**□ SANCTUARY**

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### *Oxytocin □□ □□□□□-□□□□□ □□□□*

This section exists because your own Main Book dedicates a full chapter to it, and it deserves an honest, correctly-caveated place here rather than being left out. The mechanism it addresses is real and already named elsewhere in this guide: opioids suppress the HPA axis for as long as they're used, and when they're removed, that suppressed system doesn't return gently to baseline — it rebounds, often dramatically overshooting it. Cortisol floods, the amygdala runs hot, and the nervous system reports an existential emergency with no external cause. This is the physiological reason opioid withdrawal can feel like dying even □□ □□ □□□□□□□□□□ □□□ □□ □□□□□□ □□□□ □□□□ □□ (□□□ 0) — □□ □□□□□ □□□□ □□□ □□□□□ □□

[illegible]

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Oxytocin is a direct antagonist of the cortisol-releasing cascade — it inhibits the HPA axis, functioning as a real off-switch for the alarm system opioids were keeping quiet. Your own source material is explicit and worth repeating with the same honesty: this protocol is experimental, not FDA-approved for addiction treatment, and used currently by only a small number of forward-thinking clinics and informed individuals working at the edge of recovery science. It belongs in this guide as a documented, real mechanism worth knowing exists — not as a self-directed intervention. Anyone considering it should do so with a psychiatrist or addiction medicine physician actively involved, the same standard this series has held for every other Emerging-tier addition.

Practically, this is the same category of addition as the intranasal oxytocin material already documented elsewhere in the Recovery Kernel's discontinuance series for benzodiazepine withdrawal — the mechanism (HPA-axis dampening) is the same, and the appropriate caution is the same: real, worth a conversation with a specialist, not yet a standard-of-care tool.

## Section 10 — Emergency Recognition, Restated

**MEDICAL EMERGENCY**

[illegible]

## Section 11 — Full Protocol Cross-Reference Map

| Reference | What It Offers |
|---|---|
| Recovery Kernel Opioid Guide, Section 3 | [illegible] |
| Recovery Kernel Fentanyl Guide | Section 6 ke liye contamination-specific details — testing strips, Naloxone access, aur fentanyl ki anya opioids se vishesh pharmacokinetics. |
| Recovery Kernel Ears, Eyes, and Teeth Guide, Section 5 | Full detail on injection-related infection risk referenced in Section 6. |
| Compendium Protocol 14 (Pain Management) | The parallel pain-management track referenced in Section 6 for anyone whose opioid use began with legitimate pain treatment. |
| Compendium Protocol 05 | Highest-priority protocol for this specific recovery — |

| Reference | What It Offers |
|---|---|
| (□□□□□□□□ □□□□□□□□□) | cue-triggered craving is the primary relapse mechanism in opioid recovery, more than in most other substances in this series. |
| Compendium Gene-Substance Matrix, Appendix A | Section 5 □□ □□□□□□□□□ □□ □□□□ □□ □□□□ □□□□□□□□□-□□□ □□□□□□: GABRA2 + COMT Met/Met ('Anxious Depressant Pattern') P06, P09, P10, P21 □□ □□□ □□□□ □□; □□□□ GABRA2 P01, P06, P20 □□ □□□ □□□□ □□; GABRA2 + MTHFR ('Depleted-Impulsive Pattern') P06, P07, P11, P21 □□ □□□ □□□□ □□□ □□□ □□□ □□□□□ □□□□□□□ □□□□ □□□□□□ □□ □□ □□ □□□□□□□□ □□ □□□□ □□□□□-□□□□□□□ □□□□□ |
| Recovery Kernel Main Book, Section 8 (Oxytocin Protocol) | The full source chapter behind Section 9's Emerging Addition — complete mechanism detail, and the same experimental-use caveats repeated in this guide. |
| Compendium Protocol 20, 21, C-28 (Identity Architecture) | Appropriate starting around Months 1-6 (Section 2), not before — rebuilding identity separate from the using history. |
| Recovery Kernel Complex Trauma and the Substance Connection | □□□□□□ □□□□□ □□□□□ □□□□□ □□□ □□□□□□□□□□ □□ □□□□□□□□□ □□□ □□□□ □□□□ □□; □□□□-□□□□□□□ □□□□□ □□ □□ □□□□ □□□□ □□□□ □□□□□ □□ □□ □□ □□□□□ □□ □□□□□ □□□□□□□ □□□□□□□ □ □□ □□□ - □□ □□□□□□□□ □□□ □□□□ □□ □□□□ □□ □□□ □□□□□ □□□□ □□□ |

## Section 12 — Closing

**□ SANCTUARY**

Opioid recovery addiction medicine ke kuch aise kshetron mein se ek hai jiske sabse prabhavi ilaaj ke peeche sachmuch mazboot, achhe se sthapit saboot ka aadhar hai — MAT jaan bachata hai, baar-baar, maapne yogya tareeke se. Iska upyog karna recovery ka kam roop nahi hai. Opioids dwara gheray gaye endorphin aur receptor systems dobara ban sakte hain, ek asli samay-rekha par, chahe us recovery mein lagatar dawai shaamil ho ya na ho. Sabse zyada zaroori baat, Section 0 ke anusaar, woh samay paar karna hai jab tolerance aur ummeed galat ho jaate hain — is guide mein baaki sab kuch aapko surakshit roop se uss bindu se guzarne mein madad karne ke liye maujood hai.

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**END OF GUIDE — DISCONTINUANCE PROTOCOL: OPIOIDS**

*Harm Reduction Resource — Not Medical Advice — Not a Substitute for Emergency Care*

Crisis Resources: 988 (Suicide & Crisis Lifeline, call or text) | SAMHSA: 1-800-662-4357